# City of Springfield Group Health Plan
# Enrollment Application

**Please write legibly in black or blue ink. Complete all applicable sections.**

## Enrollment Information

| Group Policy No. | Subgroup/Class No: | | AFSCME | IAFF | Non-Rep | SEIU/OPEU | SPA |
|---|---|---|---|---|---|---|---|
| **G0020720** | **HIP**: | Active | ☐P001-1101 | ☐P006-1201 | ☐P006-1301 | ☐P006-1401 | ☐P001-1501 |
| | | Retiree | ☐P004-7101 | ☐P004-7201 | ☐P004-7301 | ☐P004-7401 | ☐P004-7501 |
| | | COBRA | ☐P005-9101 | ☐P005-9201 | ☐P005-9301 | ☐P005-9401 | ☐P005-9501 |
| | **PPO**: | Active | ☐P002-1102 | ☐P006-1202 | ☐P006-1302 | ☐P006-1402 | ☐P002-1502 |
| | | Retiree | ☐P004-7102 | ☐P004-7202 | ☐P004-7302 | ☐P004-7402 | ☐P004-7502 |
| | | COBRA | ☐P005-9102 | ☐P005-9202 | ☐P005-9302 | ☐P005-9402 | ☐P005-9502 |

| Date of Full Time Hire (required) | Number of Hours Worked Per Week | Effective Date |
|---|---|---|
| month_____ day_____ year_____ | | month_____ day_____ year_____ |

## Employee Information

| Employee Last Name | First Name | M.I. |
|---|---|---|
| | | |

| Mailing Address | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Home Phone No. | Email Address | Job Title |
|---|---|---|
| | | |

Gender ☐Male ☐Female

Marital Status ☐Married ☐Single ☐Domestic Partner–If checked, are you registered? ☐Yes ☐No If yes, State:_____

Are you an active employee? ☐Yes ☐No If yes, complete Section 2A. If no, complete Section 2B.

**Section 2A – Type of New Enrollment**

I am ☐New Employee ☐Adding dependent spouse, partner, or child

Date of qualifying event:_____ *Attach proof of event*

☐New Hire ☐Marriage ☐Domestic Registration or Affidavit ☐Birth

☐Adoption ☐Court Order ☐Involuntary loss of other group coverage

☐Late Enrollment or Open Enrollment *(see disclosure for information)*

**Section 2B – Continuation of Coverage**

I am eligible for ☐COBRA

Date of qualifying event:_____

☐Termination of employment or reduced hours

☐Divorce or legal separation ☐Death of employee

☐Dependent no longer meets eligibility

## Employee and Family Members You Wish to Enroll

Ethnicity/Race Code (choose the code each family member would most closely identify with): **AIAN**-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H-**Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian

| *Name* | *Sex* | *Birth Date* | *Social Security Number–**Required** Section 111 of Public Law 110-173* | *Ethnicity /Race* |
|---|---|---|---|---|
| Employee | | | | |
| Spouse or Domestic Partner | | | | |
| Dependent Child | | | | |
| Dependent Child | | | | |
| Dependent Child | | | | |
| Dependent Child | | | | |
| Dependent Child | | | | |

If you or your spouse/domestic partner are a **court-ordered guardian** of any dependent listed above, identify and provide proof:

Name(s):_____ ☐Grandchild ☐Niece/Nephew ☐Sibling ☐Foster ☐Other:_____

**Primary language** spoken in household: ☐English ☐Español ☐Other:_____

*Para asistirle en español, por favor llame al número (800) 624-6052, ext. 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m*

## Other Coverage

**Current or Prior Coverage Information –** Do you or any person listed on this application have or have had health insurance in the last 24 months? ☐No ☐Yes If yes, complete the following **and** attach proof with dates of coverage.

| Name(s) | Insurance Carrier | Date of coverage | Will Coverage Continue? | Type of Coverage |
|---|---|---|---|---|
| | Carrier Name:<br>Policy No.:<br>Phone No.: | Begin:<br>End: | ☐Yes<br>☐No | ☐Dental<br>☐Medical<br>☐Vision |
| | Carrier Name:<br>Policy No.:<br>Phone No.: | Begin:<br>End: | ☐Yes<br>☐No | ☐Dental<br>☐Medical<br>☐Vision |
| | Carrier Name:<br>Policy No.:<br>Phone No.: | Begin:<br>End: | ☐Yes<br>☐No | ☐Dental<br>☐Medical<br>☐Vision |

**Married or Partner –** Is your spouse or domestic partner employed? ☐Yes ☐No If yes, self employed? ☐Yes ☐No

**Medicare –** If you or any person on this application has Medicare, indicate coverage: ☐Part A ☐Part B ☐Part D

| Name | Original Effective Date | Medicare No. (include alpha prefix) | Reason for Medicare Entitlement |
|---|---|---|---|
| | | | ☐Age ☐ESRD ☐Disability<br>☐Dual Entitlement |
| | | | ☐Age ☐ESRD ☐Disability<br>☐Dual Entitlement |

## Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. Also, list court ordered coverage in Other Coverage section above. Oregon law requires PacificSource to provide plan information to the custodial parent.

| Child's Name | Whose Child | Joint Custody | Custodial Parent Name | Custodial Parent Address | Custodial Parent Phone No. | Name Responsible for Insurance (court order) |
|---|---|---|---|---|---|---|
| | ☐Yours<br>☐Spouse | ☐Yes<br>☐No | | | | |
| | ☐Yours<br>☐Spouse | ☐Yes<br>☐No | | | | |
| | ☐Yours<br>☐Spouse | ☐Yes<br>☐No | | | | |

## Acknowledgement and Declaration

I acknowledge and understand that my Plan Sponsor or Plan Administrator may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health care treatment, payment, or for business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner;
- A clinic, hospital, long term care, or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or:
- An insurance carrier or group health plan.

**Health or dental information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).**

*This acknowledgement does not apply to obtaining information regarding psychotherapy notes.*

*A separate authorization will be used for this information.*

I affirm that the answers given in this application are complete and correct. I, the applicant, authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group contract.

**Employee Signature:**_____ **Date:**_____

# City of Springfield Group Health Plan Enrollment Application

**Detach and keep for your records.**

This enrollment application contains two parts: the enrollment form (pages 1–2) and information (page 3)

- **Please read the information pages carefully** to help you understand requirements of your employer's health plan.
- **Complete the enrollment form.** Be sure to answer everything that applies to you.
- **Sign and date the form.**
- **Detach the information pages and make a copy of the form.** Keep these pages with your own insurance records.
- **Return the original, completed form to your employer**.

## Employee and Family Members You Wish to Enroll

**Dependents –** Dependents of a covered employee who meet one of the following requirements may also be eligible for enrollment.

- Your legal spouse or qualified domestic partner.
- Your, your spouse's, or your qualified domestic partner's dependent children or foster child under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your qualified domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- Your sibling, niece, nephew, or grandchild under age 19 who is unmarried, or not in a qualified domestic partnership, who is related to you by blood, marriage, or qualified domestic partnership AND for whom you are the court appointed legal custodian or guardian with the expectation that the family member will live in your household for at least a year.
- A child placed for adoption with you, your spouse, or qualified domestic partner. Placed for adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption or placement for adoption. Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

No family or household members other than those listed above are eligible to enroll under your coverage.

## Special Enrollment Rights

**Special Enrollment Periods –** Both you and your family members may decline this health coverage during your initial enrollment period. If you are eligible to decline coverage and wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under Rule #1, #2, #3, or #4 below.

- *Special Enrollment Rule #1* – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, the number of hours of employment were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. You must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.
- *Special Enrollment Rule #2* – If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. You must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.
- *Special Enrollment Rule #3* – If you or your dependents become eligible for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program, you may be able to enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.
- *Special Enrollment Rule #4* – Part-time employees who have declined coverage may enroll if they move to full-time status by submitting an enrollment application within 31 days of the change. Coverage is effective the first of the month following the status change. Full-time employees must enroll during their initial enrollment period.

**Late Enrollee –** A "late enrollee" is an otherwise eligible employee or dependent who does not qualify for a special enrollment period, and who: did not enroll during the 31-day initial enrollment period; or enrolled during the initial enrollment period but discontinued coverage later. A late enrollee may enroll by submitting an enrollment application to your employer during your open enrollment period. When you or your dependents enroll during the open enrollment period, plan coverage begins on the plan's anniversary date.

## Waiving Coverage

You and your family members may decline coverage when you are first eligible. To decline coverage, complete a **Waiver of Coverage form** instead of this form. For more information on your plan's special enrollment provisions, please contact your employer.